Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: MICHAEL C MAIER 15200 SOUTHWEST FWY, STE 290 SUGAR LAND, TX 77478	MFDR Tracking #: M4-10-4839-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: INDEMNITY INSURANCE CO OF NORTH Box #: 15	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The requestor did not submit a position statement in accordance with rule §133.307.

Amount in Dispute: $82.34

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: ""The DWC-60 from the Requestor lists the dispute as a fee dispute and involves fees for a knee injection that were properly paid by the Respondent. Attached please find a letter of explanation from Coventry, the bill review company for the Respondent. They have attached exhibits indicating that the CPT code in dispute does not have a Medicare Fee Guideline amount; therefore, they deferred to the Medicaid Fee Guideline amount and paid pursuant to it.

We are responding to the above mentioned Medical Dispute Resolution request. The bill has been reanalyzed and the conclusion remains the same. Procedure code J7322 does not have a Medicare Fee Schedule allowance. Per Rule 134.202.C.2.B, "if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPC" is applicable. Therefore, payment was based on the Medicaid Fee Schedule. The provider has not submitted any documentation to substantiate their claim that the allowance $304.52 is correct".

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
11/24/09	J7322	$182.84 x 125% = $227.80	$41.17	$0.00
12/1/09	J7322	$182.84 x 125% = $227.80	$41.17	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 1/18/2010

- W1 – Workers compensation state fee schedule adjustment

Explanation of benefits dated 6/1/2010

- 45 – Charge exceeds fee schedule/maximum allowance or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W1 – Workers compensation state fee schedule adjustment.

Issues

1. Was the Requestor reimbursed in accordance with rule §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed HCPCS code J7322 (Hyaluronan or derivative, Synvisc, for intra-articular injection, per dose) and is seeking additional reimbursement. The requestor did not submit documentation to support additional reimbursement is owed. Pursuant to rule §134.203(d)(1)(2) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; or if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS. HCPCS code J7322 does not have a published Medicare rate for 2009. The Medicaid reimbursement rate for J7322 for 2009 is $182.84. The MAR amount for HCPCS J7322 is $227.80. The respondent paid the requestor $233.82 for each date of service in dispute for HCPCS code J7322. Therefore no additional payment is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	**12/14/10** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.